



# Consent and provision of information to patients in New Zealand regarding proposed treatment

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This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in Appendix A.

**Disclaimer** This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 2013  
Current: July 2019  
Review due: July 2022

**Objective:** The purpose of this statement is to assist doctors with some of the legal principles and guidelines that apply in New Zealand to the issues of patient consent and the duty to inform.

**Target audience:** Clinicians providing obstetric and gynaecological care.

**Background:** This statement was first developed in March 2013 and most recently reviewed in July 2019.

**Funding:** The development and review of this statement was funded by RANZCOG.

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## 1. Introduction

The purpose of this statement is to assist doctors with some of the legal principles and guidelines that apply in New Zealand to the issues of patient consent and the duty to inform. It is a fundamental legal and ethical principle that a patient's informed consent must be obtained before an examination or treatment may be conducted. This right is reflected in the New Zealand Bill of Rights Act 1990, the common law, and the Code of Health and Disability Services Consumers' Rights 1996 ("Code of Rights").<sup>1</sup>

The Code of Rights is by far the most important source of the law relating to the requirement for informed consent in New Zealand. The duty to obtain informed consent in the Code of Rights applies to the provision of any and all health and disability services, not just health care procedures or treatment. This extends to when a patient is participating in, or it is proposed that the patient participate in, teaching or research.<sup>2</sup>

A doctor will not be in breach of a requirement of the Code of Rights if the doctor can show that he or she took reasonable action in the circumstances to give effect to the rights, and comply with their duties under the Code.<sup>3</sup>

In addition to the Code, there are several other statutes that govern the requirements for consent in specific circumstances. Doctors must be aware of the other specific legislative requirements that govern the requirements for legally effective consent in New Zealand and should seek further information about the specific laws which apply in their sphere of practice in addition to the information provided in this statement.

## 2. Competence to Consent

Under the Code of Rights every patient is presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the patient is not competent.<sup>4</sup> A competent adult patient may refuse treatment, even where the treatment is necessary to save the patient's life or prevent serious harm. The benefits and risks associated with consenting or refusing to consent to the treatment should be explained to the patient, but the decision remains that of the patient.

The consent of a patient who is not legally competent to make the required decision is not valid. The more obvious categories of legally incompetent patients are those who are intellectually disabled or unconscious. If the doctor is unsure whether or not a patient is competent to consent to treatment, the doctor should seek a second opinion from another doctor (if possible) or seek legal advice.

If a patient is not competent to consent to the proposed examination or treatment, the examination or treatment can be provided with the consent of a guardian, or other person legally entitled to consent on behalf of the person (a welfare guardian or person authorised under an enduring power of attorney for personal care and welfare), or if no such person is available, under Right 7(4) of the Code of Rights. In rare circumstances, a court order may need to be obtained before the examination or treatment of the patient can proceed.

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<sup>1</sup> The Code of Rights is a Regulation made under the Health and Disability Commissioner Act 1994 and has full legal effect

<sup>2</sup> Right 9 of the Code of Rights.

<sup>3</sup> Clause 3 of the Code of Rights.

<sup>4</sup> Right 7(2) of the Code of Right.

### 3. Duty to Inform

#### 3.1 Sufficient information

In New Zealand the major source of the duty to inform patients is found in Right 6 of the Code of Rights. Under Right 6(1), every patient must be provided with the information that a reasonable patient, in that patient's circumstances, would expect to receive, including the following information:

- an explanation of their condition; and
- an explanation of the options available, including expected side-effects, risks, benefits, and costs of each option; and
- an estimated time of when services are likely to be provided; and
- whether they will be involved in teaching or research, including whether the research requires and has received ethical approval; and
- any other information required by legal, professional, ethical, and other relevant standards; and
- the results of tests; and
- the results of procedures.

Under Right 6(2), before making a choice or giving consent, patients have the right to the information that a reasonable patient, in that patient's circumstances, needs to make an informed choice or give informed consent.

The obligation to provide patients with information under Right 6(1) and (2) is much broader than the obligation under the common law to warn patients of material risks. The duty to inform under Right 6 extends to any information a reasonable patient, in that patient's circumstances, would expect to receive, or needs, to make an informed decision. The Health and Disability Commissioner has interpreted the duty to disclose in Right 6 very broadly to include information relating to the provider as well as information about the procedure or treatment.<sup>5</sup>

The duty to provide sufficient information is not reliant on the patient asking questions.<sup>6</sup> In addition, the information disclosure requirements in Right 6 are incorporated into the requirements for "informed consent" in Right 7(1). Therefore, consent given by a patient may be ineffective if the information requirement provisions in the Code of Rights have been breached.<sup>7</sup>

Under Right 5 patients have a right to receive information in a form, language and manner that enables the patient to understand the treatment or advice, and in an environment that enables the doctor and patient to communicate 'openly, honestly, and effectively. While a doctor is not required to ensure a patient understands the information, doctors should undertake some level of checking that the person understands the information provided.

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<sup>5</sup> This has included such matters as information about the experience of the provider in performing the particular procedure, and restrictions on a practitioner's practice where the restrictions are relevant to the service being provided to the patient by the practitioner.

<sup>6</sup> Doctors have a duty to answer questions honestly and accurately under Right 6(3) of the Code of Rights. Patients are also entitled to receive, on request, a written summary of the information provided (Right 6(4)).

<sup>7</sup> This is because the consent will not have been given in accordance with the requirements for informed consent set out in Right 7(1) of the Code of Rights. This is in contrast to other jurisdictions where a breach of the duty to inform does not in itself vitiate the patient's consent (see *Rogers v Whitaker* (1992), 175 CLR 479 (HCA)).

It is the doctor who provides the treatment who is responsible for ensuring that the patient has sufficient information to make an informed choice and give informed consent. Therefore, where another doctor, or health practitioner is assigned the task of providing the patient with the necessary information and/or obtaining the patient's consent, the doctor performing the treatment retains ultimate responsibility for taking all reasonable steps to ensure that the patient has been provided with sufficient information and has given properly informed consent.

The Medical Association of New Zealand Code of Ethics (2014) specifically notes that in addition to ensuring that patients understand the nature of their problems, the range of possible solutions, and likely benefits to enable them to make informed choices, doctors must also provide information on the cost of the treatments to assist patients to make informed choices.<sup>8</sup>

### 3.2 When resource limitations impact the treatment that can be offered

Resource limitation is a significant and relevant part of the environment of professional medical practice. The Medical Council of New Zealand provides guidance in their document "Safe practice in an environment of resource limitation" (September 2018). Practitioners are required to: Strive to use resources efficiently, consistent with good evidence-based patient care, and balance their duty of care to each patient with their duty of care to the community and wider population.

With respect to elective procedures, where there are delays in the publicly-funded health system and the public system is not the only avenue for treatment, you should also advise the patient if services may be obtained privately. Where possible, a range of private providers should be offered.

### 3.3 When English is the patient's second language

When the patient's first language is not English, the doctor must assess whether it is necessary or desirable to use an interpreter to assist in obtaining the patient's informed consent. If an interpreter is required, it is highly desirable that an independent, professionally qualified health interpreter assist either in person or by telephone. If a professionally qualified interpreter is not available (or is not acceptable to the patient), assistance may be sought from family members or bilingual staff may be used if the patient consents.

When an interpreter has been used this should be noted in the patient's clinical record, along with the interpreter's name and status (professional interpreter, family member etc.) and, if possible, a note signed by the interpreter to certify that they believe the patient understands the information provided.<sup>9</sup>

### 3.4 When a patient does not want to be fully informed

In some instances a patient may indicate that she does not wish to be fully informed about a proposed treatment. While the doctor is not required to burden a patient with unwanted information, the doctor is still obligated to explain the procedure to the patient (at least in broad terms), the alternatives to the treatment, the likelihood of a satisfactory outcome, and the more serious and common possible side effects or complications.<sup>10</sup>

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<sup>8</sup> Medical Council NZ, Code of Ethics, Responsibilities to the patient (4) 2014.

<sup>9</sup> Medical Council of New Zealand Statement "Information, choice of treatment and informed consent" March 2011.

<sup>10</sup> In relation to a patient's right not to hear the details necessary to understand the proposed surgery the High Court has said that "Waiving the right to know may not mean that the procedure can go ahead" and that "The upshot of all this is that the legal position in New Zealand as to a patient's ability to waive the right to know – to refuse to hear the detail necessary for informed consent – is uncertain ... But the weight of authority seems to be that the surgeon should insist on the patient listening to sufficient detail, at least where major surgery carrying high risks is proposed." (Harman v Director of

If the treatment proposed involves an invasive procedure or major surgery that carries high risks, the doctor may insist that the patient is provided with sufficient information to enable her to understand the risks and benefits of the options (unless this is likely to cause the patient harm). Alternatively, the doctor may decline to provide the treatment, as the patient will not be able to give informed consent as is required by the law.<sup>11</sup>

It is very important that discussions with the patient are fully recorded in the patient's clinical record. It would also be prudent to have the patient sign a written declaration that she was offered a full explanation of the treatment and all relevant information, but that she refused to be fully informed.

Information should not be withheld from a patient unless the doctor believes that the patient's physical or mental health could be seriously harmed by provision of the information

## 4. Documentation

### 4.1 Clear contemporaneous notes

Doctors should keep clear, contemporaneous notes of the advice and information with which they have provided a patient, including the specific risks that have been discussed and the provision of information or literature (if any). It may be that a reference to the advice given is needed in a letter to a referring doctor. Where appropriate, a note should be made of the fact that the patient has received written or other information in a set form.

If you are placed in a position where you are unable to provide a preferred treatment, you should inform the patient (and/or their caregivers/family/whānau where possible) of the reasons for the denial of service, what the best available option is and what that involves. This discussion should be documented<sup>12</sup>.

### 4.2 Requirement for written consent

The Code of Rights provides that written consent is required if:<sup>13</sup>

- (a) the patient is to participate in any research; or
- (b) the procedure is experimental; or
- (c) the patient will be under general anaesthetic; or
- (d) there is significant risk of adverse effects to the patient.

The requirement for written consent is subject to clause 3 of the Code of Rights. The doctor will not be in breach of the duty to obtain consent in writing if he or she has taken reasonable actions in the circumstances to give effect to the duty. "The circumstances" includes the patient's clinical circumstances.

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Proceedings (High Court, Auckland, 12 March 2009)). And refer to the Medical Council of New Zealand Statement "Information, choice of treatment and informed consent" March 2011.

<sup>11</sup> Medical Council of New Zealand Statement "Information, choice of treatment and informed consent," March 2011.

<sup>12</sup> Medical Council of New Zealand Statement "Safe practice in an environment of resource limitation" September 2018.

<sup>13</sup> Right 7(6) of the Code of Rights.

It is also useful to note that while standard consent forms are useful, they are not a sufficient substitute for actual medical advice provided in a consultation between the patient and treating doctor.

## 5. Demonstration procedures, teaching and research

Where a Fellow is a visiting surgeon conducting a demonstration/teaching session for peers on a patient of another doctor, the visiting surgeon must still undertake a consultation covering the nature and teaching format for the surgery, and obtain written consent from the patient for the procedure. This is necessary even if the patient's treating specialist has already undertaken a consultation and obtained consent (as the treating specialist may not have been in a position to give full details of the demonstration surgery and possible complications).

The rights in the Code of Rights extend to occasions when a patient is participating in, or it is proposed that a patient participate in, teaching or research, and patients must be told of any proposed such participation including in the case of research whether the research requires ethical committee approval and if so if it has received the approval.<sup>14</sup>

Fellows are also referred to statement [https://www.ranzcog.edu.au/RANZCOG\\_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Guidelines-for-visiting-surgeons-conducting-demonstration-sessions-\(C-Gen-6\)-Mar-18.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Guidelines-for-visiting-surgeons-conducting-demonstration-sessions-(C-Gen-6)-Mar-18.pdf?ext=.pdf) for additional information.

## 6. Collection and use of human tissue

Specific rights in respect of the removal and use of an individual's body parts and bodily substances removed or obtained in the course of a health care procedure are set out in Rights 7(9) and (10) as follows:

- (a) under Right 7(9) every patient has the right to make a decision about the return or disposal of any such body parts or bodily substances;
- (b) under Right 7(10) any such body parts or bodily substances may be stored, preserved, or utilised only with the informed consent of the patient, or for the purposes set out in Right 7(10)(b) or (c).<sup>15</sup>

These provisions apply whenever it is proposed, in the course of a health care procedure, that body parts or substances be removed from a patient's body, regardless of the reason for removal. Patients should be informed of what body part is to be removed and what is intended to happen with that part.

Patients with diminished competence

Patients with diminished competence have the right to receive information, make informed choices and give

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<sup>14</sup> Right 6(1)(d) and Right 9 of the Code of Rights.

<sup>15</sup> For the purposes of research that has received the approval of an ethics committee (Right 7(1)(b)), or for the purposes of a professionally recognised quality assurance programme or an external audit or evaluation of services (Right 7(10)(c)).

informed consent to the level of their understanding.<sup>16</sup> The level of competence required depends on the nature of the decision being made. Mental disorder or intellectual disability do not of themselves necessarily mean a patient is incompetent to consent.

## 7. Providing care and treatment to incompetent patient under Right 7(4) of the Code of Rights

Under New Zealand law, Right 7(4) of the Code of Rights sets out the circumstances in which treatment can be provided to a patient without consent. Under Right 7(4), treatment may be provided to an incompetent patient, where no-one legally entitled to consent for the patient is available, if:

- (a) the treatment is in the patient's best interests; and
- (b) reasonable steps have been taken to ascertain the views of the patient; and
- (c) either having regard to those views, the doctor believes, on reasonable grounds, that the treatment is consistent with the informed choice the patient would make if she were competent; or if the patient's views have not been ascertained, the doctor takes into account the views of other suitable persons who are interested in the welfare of the patient and available to advise the doctor.

Suitable persons' who are interested in the patient's welfare might include next of kin, the patient's permanent caregivers, family and whanau, and/or their GP. Where the patient's views cannot be ascertained, doctors must "take into account" the views of other suitable persons interested in the patient's welfare. However, there is no requirement that the doctor can only provide treatment in accordance with these views.

## 8. Treatment in an emergency

A competent adult patient may refuse treatment in an emergency. If the patient is not competent, and urgent treatment is needed to save the patient's life or avoid serious harm, and the treatment is in the patient's best interests, a doctor can (and in most cases must) provide immediate treatment necessary to preserve the life or health of that patient. Only treatment necessary to preserve life or prevent serious harm should be carried out at this time.

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<sup>16</sup> Right 7(3) of the Code of Rights.



## 9. Consent from Children (under 18 years of age)

The starting point with respect to children giving informed consent under the Code of Rights is the presumption of competence in Right 7(2). All the rights in the Code of Rights apply equally to all patients regardless of age. Age is simply one of a number of relevant factors to take into account when determining a child's competence to make a particular decision. This position reflects the position adopted by the courts in recent years commonly referred to as the 'Gillick competency' test.<sup>17</sup>

Ultimately, an assessment of whether a particular child is competent to give consent to a proposed treatment will depend on the understanding and maturity of the child, and the gravity of the treatment. As long as the child is capable of making such a decision, her consent will be valid.

In New Zealand, the statutory law relating to consent for medical treatment in relation to children is found in the Care of Children Act 2004. Under section 36, a child aged 16 years and over has the statutory right to consent and refuse consent to medical treatment "as if the child were of full age". This means that the child's guardians could not override a competent 16 or 17 year old's consent or refusal to consent. However, guardians continue to have a guardianship role until a child is 18 years old, and are able to consent or refuse consent for an incompetent 16 and 17 year old in most situations.

The Care of Children Act 2004 does not expressly address what happens in the case of a 'Gillick competent' child who is under 16 years of age. However, under the Code of Rights, a 'Gillick competent' child under 16 years of age can consent to treatment for which they are competent, and a guardian's consent will not be required.

Even where a child has capacity to consent for themselves, it will, in most cases, still be appropriate for the child's guardians to be involved in the consent process. There will be exceptions to this, including a situation where a competent child expressly refuses to have his or her guardians involved. In this situation, if the treatment is risky or controversial, special care is required and advice from a senior colleague or legal advice should be sought.

Persons entitled to consent on behalf of a child must be acting in the best interests of the child. The advice of a senior colleague, or legal advice, should be sought if a guardian refuses consent to treatment that the doctor responsible for the child's care believes is in the child's best interests, or where there are strong conflicting views of more than one guardian as to whether treatment should proceed.

### 9.1 Disclosure of information to guardians

Where a child is incompetent to consent and the child's guardian is required to consent to treatment on the child's behalf, the guardian must be sufficiently informed in order to make an informed choice and give informed consent, and will usually be entitled to all the information that the patient requires to give informed consent.<sup>18</sup> The child's parent or guardian is also entitled to any information relating to the child generally, unless it is considered not to be in the child's best interests to disclose that information.<sup>19</sup>

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<sup>17</sup> *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER402 (House of Lords).

<sup>18</sup> A legal guardian is considered a "consumer" for the purposes of Rights 5, 6, 7(1), 7(7) to 7(10), and 10, of the Code of Rights, and the child's representative under the Health Information Privacy Code.

<sup>19</sup> Rule 11(1)(a)(ii) of the Health Information Privacy Code. A child's parent or guardian may request information about the child under section 22F of the Health Act 1956.

If the child is competent to consent to treatment, and to exercise their rights under the Health Information Privacy Code, and the child does not want their health information disclosed to their parent or guardian, section 22F of the Health Act 1956 allows for the refusal of any request by the parent or guardian.<sup>20</sup> The rules relating to disclosure of information in the Health Information Privacy Code will apply and the information should only be disclosed if an exception in Rule 11 applies.

### 9.2 Termination of pregnancy

Under section 38 of the Care of Children Act 2004, a child of any age who is competent can consent to the termination of her pregnancy.

### 9.3 Sterilisation

Sterilisation of intellectually disabled persons remains a contentious area of law.

The law on sterilisation of incompetent children is not wholly clear in New Zealand and may differ depending on whether the sterilisation is for therapeutic or contraceptive reasons, and the level of disability of the patient.<sup>21</sup> However, parental consent is not a sufficient basis to perform a sterilisation procedure on a child who lacks capacity to consent by reason of age alone.<sup>22</sup> Parental consent may be sufficient where a child lacks capacity due to mental incompetence if the relevant doctor is satisfied that sterilisation is (a) in the child's best interests and (b) it is the least drastic intervention in the circumstances. Legal advice should usually be sought when considering sterilisation of a child.

Court intervention is required for the sterilisation of a mentally incompetent adult, unless the procedure is a medical emergency, or is carried out with the consent of a welfare guardian to save the person's life or to prevent serious harm to the person's health.<sup>23</sup>

Doctors should also be aware of the obligation under section 8 of the Contraception, Sterilisation, and Abortion Act 1977 to report all sterilisations (and the reasons for the operation) to the Director-General of Health.

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<sup>20</sup> If a parent or guardian requests their child's information the request must be dealt with in accordance with section 22F of the Health Act 1956 and Rule 11(4) of the Health Information Privacy Code. The information must be disclosed unless disclosure would be contrary to the child's interests, or the doctor has reasonable grounds for believing that the child would not want the information disclosed, or if there would be good grounds for refusing the request under Part 4 of the Privacy Act 1993 if the request had been made by the child concerned.

<sup>21</sup> In Australia and England a court order is required for the sterilisation of mentally incompetent minors irrespective of parental consent.

<sup>22</sup> Section 7 of the Contraception, Sterilisation and Abortion Act 1977.

<sup>23</sup> Section 9(1) of the Contraception, Sterilisation, and Abortion Act 1977

## 10. Contraception for mentally incompetent females

Doctors may administer contraceptives to a woman or girl who is 'mentally subnormal' as defined in section 4(2) of the Contraception, Sterilisation, and Abortion Act 1977 as long as the treatment is in the best interests of the patient. An assessment of competence will need to be made in terms of the definition in section 4(2) of the Act.<sup>24</sup>

Where a mentally incompetent patient does not come within the definition of 'mentally subnormal' in the Contraception, Sterilisation, and Abortion Act 1977, consent to contraception may be authorised by the court under the Protection of Personal and Property Rights Act 1988. These are difficult cases and legal advice should be sought before proceeding without a court order.<sup>25</sup>

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<sup>24</sup> Under section 4(2) a female is mentally subnormal if she is suffering from subnormality of intelligence as a result of arrested or incomplete development of mind to the extent that she is incapable of living an independent life or of guarding herself against serious exploitation or common physical dangers or to the extent that she is incapable of understanding the effective use of contraceptives or the desirability or need for their use.

<sup>25</sup> Doctors should also be aware of their duties in respect of contraception, sterilisation and other reproductive health services in section 174 of the Health Practitioners Competence Assurance Act 2003.

## Links to other College statements

Guidelines for visiting surgeons conducting demonstration sessions (C-Gen 06)

[https://www.ranzcog.edu.au/RANZCOG\\_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Guidelines-for-visiting-surgeons-conducting-demonstration-sessions-\(C-Gen-6\)-Mar-18.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Guidelines-for-visiting-surgeons-conducting-demonstration-sessions-(C-Gen-6)-Mar-18.pdf?ext=.pdf)

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)

[https://www.ranzcog.edu.au/RANZCOG\\_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-\(C-Gen-15\)-Review-March-2016.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-(C-Gen-15)-Review-March-2016.pdf?ext=.pdf)

## Other resources

For more information on patients rights, and health providers obligations in New Zealand, refer to the New Zealand Health and Disability Services Commissioner's Code of Consumer Health:

<https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/>

All doctors practising in New Zealand should be familiar with the following guidance and statements from the Medical Council of New Zealand:

- “Coles Medical Practice in New Zealand” (2013 edition) available at:  
<https://www.mcnz.org.nz/assets/News-and-Publications/V6-Coles-Medical-Book-2017.pdf>
- “Information, Choice of Treatment, and Informed Consent” (March 2011) available at:  
<http://www.mcnz.org/assets/News-and-Publications/Statements/Information-choice-of-treatment-and-informed-consent.pdf><sup>26</sup>
- “Safe practice in an environment of resource limitation” (September 2018)  
<https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf>
- Australian Medical Association “The Doctor’s Role in Stewardship of Health Care Resources” (2016). Available at:  
<https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20the%20Doctor%27s%20Role%20in%20Stewardship%20in%20Health%20Care%20Resources%202016.pdf?file=1&type=node&id=44607>

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<sup>26</sup> This statement may be used by the Health Practitioner’s Disciplinary Tribunal, the Medical Council and the Health and Disability Commissioner as a standard by which a medical practitioner’s conduct is measured.

## Appendices

### Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics
Associate Professor Ian Pettigrew	Member and EAC Representative
Dr Kristy Milward	Member and Councillor
Dr Will Milford	Member and Councillor
Dr Frank O'Keeffe	Member and Councillor
Professor Sue Walker	Member
Dr Roy Watson	Member and Councillor
Dr Susan Fleming	Member and Councillor
Dr Sue Belgrave	Member and Councillor
Dr Marilyn Clarke	ATSI Representative
Associate Professor Kirsten Black	Member
Dr Thangeswaran Rudra	Member
Dr Nisha Khot	Member and SIMG Representative
Dr Judith Gardiner	Diplomate Representative
Dr Angela Brown	Midwifery Representative
Ms Ann Jorgensen	Community Representative
Dr Rebecca Mackenzie-Proctor	Trainee Representative
Prof Caroline De Costa	Co-opted member (ANZJOG member)

### Appendix B Overview of the development and review process for this statement

#### *i. Steps in developing and updating this statement*

This statement was developed in March 2013 and most recently reviewed in July 2019. The Women's Health Committee carried out the following steps in reviewing this statement:

- At the March 2019 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix A part ii).

#### *ii. Grading of recommendations*

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

#### Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.